		FOR OHF USE					

LL1

2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0041780

Facility Name: ROSE GARDEN CONVALESCENT CENTER

Address: 1629 GARDNER LANE (Number) PEORIA HEIGHTS (City) 61614 (Zip Code)

County: PEORIA

Telephone Number: (847) 647-1717 **Fax #** (847) 647-0222

IDPA ID Number: 36-4069174

Date of Initial License for Current Owners: 03/01/96

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2001 to 12/31/2001 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) SHERWIN I. RAY
(Title) PRESIDENT

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, PARTNER
(Firm Name & Address) KRUPNICK BOKOR KAGDA & BROOKS, LTD, 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number ROSE GARDEN CONVALESCENT CENTER # 0041780 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	55	Skilled (SNF)	55	20,075	1
2		Skilled Pediatric (SNF/PED)			2
3	55	Intermediate (ICF)			3
4		Intermediate/DD	55	20,075	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	110	TOTALS	110	40,150	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			1,771	1,771	8
9	SNF/PED					9
10	ICF	27,270	4,814		32,084	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	27,270	4,814	1,771	33,855	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.32%

D. How many bed-hold days during this year were paid by Public Aid?
236 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 03/01/96

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 03/01/96 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 24 and days of care provided 1,771

Medicare Intermediary ADMINISTAR

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/01 Fiscal Year: 12/31/01

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number ROSE GARDEN CONVALESCENT CENTE # 0041780 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	151,599	17,320	4,084	173,003		173,003	0	173,003			1
2	Food Purchase		119,928		119,928	(11,607)	108,321	(560)	107,761			2
3	Housekeeping	97,349	20,412	0	117,761		117,761	0	117,761			3
4	Laundry	30,242	9,954	0	40,196		40,196	0	40,196			4
5	Heat and Other Utilities			60,004	60,004		60,004	378	60,382			5
6	Maintenance	30,356	23,842	20,661	74,859		74,859	8,898	83,757			6
7	Other (specify):*			7,065	7,065		7,065	0	7,065			7
8	**TOTAL General Services**	309,546	191,456	91,814	592,816	(11,607)	581,209	8,716	589,925			8
	B. Health Care and Programs											
9	Medical Director	0		6,598	6,598		6,598	0	6,598			9
10	Nursing and Medical Records	954,230	64,658	1,140	1,020,028		1,020,028	16,779	1,036,807			10
10a	Therapy	47,868	4,969	76,548	129,385		129,385	5,549	134,934			10a
11	Activities	38,338	1,482	0	39,820		39,820	0	39,820			11
12	Social Services	21,566		3,338	24,904		24,904	0	24,904			12
13	Nurse Aide Training			0	0		0	0	0			13
14	Program Transportation			0	0		0	0	0			14
15	Other (specify):*				0		0	0	0			15
16	**TOTAL Health Care and Programs**	1,062,002	71,109	87,624	1,220,735	0	1,220,735	22,328	1,243,063			16
	C. General Administration											
17	Administrative	96,330		23,000	119,330		119,330	26,462	145,792			17
18	Directors Fees			0	0		0	0	0			18
19	Professional Services			194,906	194,906		194,906	(154,710)	40,196			19
20	Dues, Fees, Subscriptions & Promotions			22,350	22,350		22,350	(5,631)	16,719			20
21	Clerical & General Office Expenses	89,830	8,083	109,043	206,956		206,956	(30,137)	176,819			21
22	Employee Benefits & Payroll Taxes			191,754	191,754	11,607	203,361	0	203,361			22
23	Inservice Training & Education			1,156	1,156		1,156	326	1,482			23
24	Travel and Seminar			878	878		878	344	1,222			24
25	Other Admin. Staff Transportation			7,472	7,472		7,472	1,569	9,041			25
26	Insurance-Prop.Liab.Malpractice			95,710	95,710		95,710	3,045	98,755			26
27	Other (specify):*			0	0		0	25,914	25,914			27
28	**TOTAL General Administration**	186,160	8,083	646,269	840,512	11,607	852,119	(132,818)	719,301			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,557,708	270,648	825,707	2,654,063	0	2,654,063	(101,774)	2,552,289			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number ROSE GARDEN CONVALESCENT CENTER #0041780 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			4,681	4,681		4,681	121,497	126,178			30
31	Amortization of Pre-Op. & Org.			215	215		215	0	215			31
32	Interest			30,882	30,882		30,882	265,686	296,568			32
33	Real Estate Taxes			53,647	53,647		53,647	0	53,647			33
34	Rent-Facility & Grounds			378,473	378,473		378,473	(374,049)	4,424			34
35	Rent-Equipment & Vehicles			44,470	44,470		44,470	(5,784)	38,686			35
36	Other (specify):*				0		0	0	0			36
37	**TOTAL Ownership**			512,368	512,368	0	512,368	7,350	519,718			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation				0		0	0	0			38
39	Ancillary Service Centers		62,137	92,647	154,784		154,784	(19,270)	135,514			39
40	Barber and Beauty Shops				0		0	0	0			40
41	Coffee and Gift Shops				0		0	0	0			41
42	Provider Participation Fee			60,225	60,225		60,225	0	60,225			42
43	Other (specify):*				0		0	0	0			43
44	**TOTAL Special Cost Centers**	0	62,137	152,872	215,009	0	215,009	(19,270)	195,739			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,557,708	332,785	1,490,947	3,381,440	0	3,381,440	(113,694)	3,267,746			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number ROSE GARDEN CONVALESCENT CENTER # 0041780 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(6,538)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(560)	2		13
14	Non-Care Related Interest	0	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)		25		16
17	Non-Care Related Fees	0	20		17
18	Fines and Penalties	(15,528)	21		18
19	Entertainment	0	20		19
20	Contributions	(1,510)	20		20
21	Owner or Key-Man Insurance	0	22		21
22	Special Legal Fees & Legal Retainers	(15,368)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	0	27		24
25	Fund Raising, Advertising and Promotional	(2,475)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(4,627)	20		28
29	Other-Attach Schedule SEE PAGE 5A	1,557			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (45,049)		$ 0	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(68,645)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (68,645)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (113,694)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

ROSE GARDEN CONVALESCENT CENTER

ID# 0041780

Report Period Beginning: 01/01/2001

Ending: 12/31/2001

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$ 1557	6	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	1,557		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number ROSE GARDEN CONVALESCENT CENTER # 0041780 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(560)	0	0	0	0	0	0	0	0	0	0	(560)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	378	0	0	0	0	0	0	0	0	378	5
6	Maintenance	1,557	0	7,341	0	0	0	0	0	0	0	0	8,898	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	997	0	7,719	0	0	0	0	0	0	0	0	8,716	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	16,779	0	0	0	0	0	0	0	0	16,779	10
10a	Therapy	0	(1,080)	6,629	0	0	0	0	0	0	0	0	5,549	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	(1,080)	23,408	0	0	0	0	0	0	0	0	22,328	16
	C. General Administration													
17	Administrative	0	(8,000)	34,462	0	0	0	0	0	0	0	0	26,462	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(15,368)	(143,000)	3,658	0	0	0	0	0	0	0	0	(154,710)	19
20	Fees, Subscriptions & Promotions	(8,612)	0	2,981	0	0	0	0	0	0	0	0	(5,631)	20
21	Clerical & General Office Expenses	(15,528)	(66,000)	51,391	0	0	0	0	0	0	0	0	(30,137)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	326	0	0	0	0	0	0	0	0	326	23
24	Travel and Seminar	0	0	344	0	0	0	0	0	0	0	0	344	24
25	Other Admin. Staff Transportation	0	0	1,569	0	0	0	0	0	0	0	0	1,569	25
26	Insurance-Prop.Liab.Malpractice	0	0	3,045	0	0	0	0	0	0	0	0	3,045	26
27	Other (specify):*	0	0	25,914	0	0	0	0	0	0	0	0	25,914	27
28	**TOTAL General Administration**	(39,508)	(217,000)	123,690	0	0	0	0	0	0	0	0	(132,818)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(38,511)	(218,080)	154,817	0	0	0	0	0	0	0	0	(101,774)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number ROSE GARDEN CONVALESCENT CENTER # 0041780 **Report Period Beginning:** 01/01/2001 **Ending:** 12/31/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(6,538)	121,033	7,002	0	0	0	0	0	0	0	0	121,497	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	254,012	11,674	0	0	0	0	0	0	0	0	265,686	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(378,473)	4,424	0	0	0	0	0	0	0	0	(374,049)	34
35	Rent-Equipment & Vehicles	0	(10,491)	4,707	0	0	0	0	0	0	0	0	(5,784)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(6,538)	(13,919)	27,807	0	0	0	0	0	0	0	0	7,350	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	(19,270)	0	0	0	0	0	0	0	0	0	(19,270)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	(19,270)	0	0	0	0	0	0	0	0	0	(19,270)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(45,049)	(251,269)	182,624	0	0	0	0	0	0	0	0	(113,694)	45

Facility Name & ID Number ROSE GARDEN CONVALESCENT CENTER # 0041780 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED SCHEDULE		SEE ATTACHED SCHEDULE		CAREPLUS MGMT		
				ROSE GARDEN CARE CENTER LLC		
					NILES	
				CAREPLUS REHABILITATIVE SERVICES		
					NILES	

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	MANAGEMENT FEES	$ 8,000	CAREPLUS MGMT INC		$	$ (8,000)	1
2	V	19	ADMIN. CONSULTANT FEES	131,000	" "			(131,000)	2
3	V	19	DATA PROCESSING FEES	12,000	" "			(12,000)	3
4	V	21	CLERICAL FEES	66,000	" "			(66,000)	4
5	V	35	COMPUTER LEASE	10,491	" "			(10,491)	5
6	V								6
7	V	34	RENT	378,473	ROSE GARDEN CARE CENTER LLC			(378,473)	7
8	V	30	SL DEPRECIATION		" "		121,033	121,033	8
9	V	32	INTEREST		" "		254,012	254,012	9
10	V								10
11	V								11
12	V	10a	THERAPY SERVICES	36,222	CAREPLUS REHABILITATIVE SERVICES		35,142	(1,080)	12
13	V	39	ANCILLARY THERAPY	128,674	" "		109,404	(19,270)	13
14	Total			$ 770,860			$ 519,591	$ * (251,269)	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number ROSE GARDEN CONVALESCENT CENTER # 0041780 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY SALARIES	$	CAREPLUS MGMT INC	100.00%	$	$	15
16	V	5	ELECTRICITY		" "		378	378	16
17	V	6	REPAIRS		" "		215	215	17
18	V	6	MAINTENANCE SALARIES		" "		7,126	7,126	18
19	V	10	NURSING SALARIES		" "		16,779	16,779	19
20	V	10a	THERAPY SALARIES		" "		907	907	20
21	V	10a	THERAPY SUPPLIES/SERVICES		" "		5,722	5,722	21
22	V	17	ADMIN SALARIES		" "		34,462	34,462	22
23	V	19	PROFESSIONAL FEES		" "		3,658	3,658	23
24	V	20	DUES/LICENSES/WANT ADS		" "		2,981	2,981	24
25	V	21	OFFICE EXPENSES		" "		13,601	13,601	25
26	V	21	CLERICAL SALARIES		" "		37,790	37,790	26
27	V	23	SEMINARS		" "		326	326	27
28	V	24	TRAVEL		" "		344	344	28
29	V	25	TRANSPORTATION		" "		1,569	1,569	29
30	V	26	INSURANCE		" "		3,045	3,045	30
31	V	27	EMPLOYEE BENEFITS		" "		25,914	25,914	31
32	V	30	SL DEPRECIATION		" "		7,002	7,002	32
33	V	32	INTEREST		" "		11,674	11,674	33
34	V	34	OFFICE RENT		" "		4,424	4,424	34
35	V	35	EQUIP RENT/AUTO LEASE		" "		4,707	4,707	35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 182,624	$ * 182,624	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ROSE GARDEN CONVALESCENT CENT # 0041780 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week: Hours	Percent	Compensation Included in Costs for this Reporting Period**: Description	Amount	Schedule V. Line & Column Reference	
1	CAREPLUS MGMT ALLOCATIONS:								$		1
2	JAKOB BAKST	DIR OPERATIONS	ADMIN, CONSUL	27.83	SEE ATTACHED			SALARY	10,325	17-7	2
3	SHERWIN I. RAY	PRESIDENT	ADMIN, FINANC	27.83	SCHEDULES			" "	10,325	17-7	3
4	JOE ZIMMERMAN	CFO	FINANCIAL	2.50	" "			" "	6,327	21-7	4
5	JANICE CLAFFORD	CONTROLLER	CLERICAL	0.50	" "			" "	2,209	21-7	5
6	ROMY MACASAET	RN CONSULTANT	NURSING	1.00	" "			" "	4,937	10-7	6
7	JAMEE O'BRIEN	REGIONAL MANAG	ADMINISTRATIV	2.00	" "			" "	5,758	17-7	7
8	TAMMY ORR	RN CONSULTANT	NURSING	2.00	" "			" "	6,573	10-7	8
9											9
10	ERIC ROTHNER (HUNTER MGMT LLC)		CONSULTING	27.83	" "			MGMT FEES	15,000	17-3	10
11											11
12											12
13								TOTAL	$ 61,454		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number ROSE GARDEN CONVALESCENT CENTER # 0041780 Report Period Beginning: 01/01/2001 Ending: 2/31/2001

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CAREPLUS MGMT
Street Address: 5940 W. TOUHY
City / State / Zip Code: NILES, IL 60714
Phone Number: (847) 647-1717
Fax Number: (847) 647-0222

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIETARY SALARIES	PATIENT DAYS	606,625	15	$ 83,890	$ 83,890		$ 0	1
2	5	ELECTRICITY	" "	606,625	15	6,767		33,855	378	2
3	6	REPAIRS	" "	606,625	15	3,858		33,855	215	3
4	6	MAINTENANCE SALARIES	" "	606,625	15	127,691	127,691	33,855	7,126	4
5	10	NURSING SALARIES	" "	606,625	15	300,646	300,646	33,855	16,779	5
6	10a	THERAPY SALARIES	" "	606,625	15	15,283		33,855	907	6
7	10a	THERAPY SUPPLIES/SERVICES	" "	606,625	15	96,375		33,855	5,722	7
8	17	ADMIN SALARIES	" "	606,625	15	617,499	617,499	33,855	34,462	8
9	19	PROFESSIONAL FEES	" "	606,625	15	65,550		33,855	3,658	9
10	20	DUES/LICENSES/WANT ADS	" "	606,625	15	53,408		33,855	2,981	10
11	21	OFFICE EXPENSES	" "	606,625	15	243,714		33,855	13,601	11
12	21	CLERICAL SALARIES	" "	606,625	15	677,141	677,141	33,855	37,790	12
13	23	SEMINARS	" "	606,625	15	5,849		33,855	326	13
14	24	TRAVEL	" "	606,625	15	6,170		33,855	344	14
15	25	TRANSPORTATION	" "	606,625	15	28,114		33,855	1,569	15
16	26	INSURANCE	" "	606,625	15	54,564		33,855	3,045	16
17	27	EMPLOYEE BENEFITS	" "	606,625	15	464,335		33,855	25,914	17
18	30	SL DEPRECIATION	" "	606,625	15	125,471		33,855	7,002	18
19	32	INTEREST	" "	606,625	15	209,175		33,855	11,674	19
20	34	OFFICE RENT	" "	606,625	15	79,265		33,855	4,424	20
21	35	EQUIP RENT/AUTO LEASE	" "	606,625	15	84,343		33,855	4,707	21
22										22
23										23
24										24
25	TOTALS					$ 3,349,108	$ 1,806,867		$ 182,624	25

Facility Name & ID Number ROSE GARDEN CONVALESCENT CENTE # 0041780 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	RELATED PARTY : ROSE GARDEN CENTER LLC						$	$			$	1
2	AMERICAN NATIONAL BANK		X	MORTGAGE	$28,571.00	9/98	3,600,000	3,303,678	08/2018	7.2100	246,186	2
3												3
4												4
5												5
	Working Capital											
6	CAREPLUS MGMT INC	X		WORKING CAPITAL	DEMAND			195,000		PRIME +	10,241	6
7	SHAREHOLDER / PARTNER	X		WORKING CAPITAL				540,000			20,641	7
8	CAREPLUS MGMT INC	X		CAPITAL IMPRV LOAN				76,869			5,826	8
9	TOTAL Facility Related				$28,571.00		$ 3,600,000	$ 4,115,547			$ 282,894	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$ 0	$ 0			$ 0	14
15	TOTALS (line 9+line14)						$ 3,600,000	$ 4,115,547			$ 282,894	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number ROSE GARDEN CONVALESCENT CENTER # 0041780 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2000 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	51,190	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	51,837	2
3. Under or (over) accrual (line 2 minus line 1).	$	647	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)	$	53,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	53,647	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1996	26,760	8
	1997	27,457	9
	1998	31,199	10
	1999	50,679	11
	2000	51,837	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2000 TAX BILL.

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME ROSE GARDEN CONVALESCENT CENTER COUNTY PEORIA

FACILITY IDPH LICENSE NUMBER 0041780

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	14-15-426-004	NURSING HOME	$ 51,837.30	$ 51,837.30
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 51,837.30	$ 51,837.30

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number ROSE GARDEN CONVALESCENT CENTER # 0041780 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 25,000 B. General Construction Type: Exterior CEMENT BLOCK & I Frame METAL BEAM Number of Stories 1-NO BASEMENT

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 16,150
2. Number of Years Over Which it is Being Amortized: 5 YEARS
3. Current Period Amortization: 215
4. Dates Incurred: 03/01/96

Nature of Costs: ORGANIZATION EXPENSE
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME	400,860	1998	$ 126,500	1
2					2
3	TOTALS	400,860		$ 126,500	3

Facility Name & ID Number ROSE GARDEN CONVALESCENT CENTER # 0041780 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	RELATED PARTY: ROSE GARDEN CARE CENTER LLC				$	$		$	$	$	4
5	110		1998		2,536,069	65,025	39	65,025		214,070	5
6					884,255	22,672	39	22,672		131,337	6
7											7
8	RELATED PARTY : CAREPLUS MANAGEMENT					7,002		7,002			8
	Improvement Type**										
9	COOLER DOOR			1996	1,675	43	39	43		292	9
10	LIGHTING			1997	2,293	59	39	59		351	10
11	PARKING LOT REPAIRS			1998	3,628	242	15	242		1,089	11
12	BUMPERS/HANDRAILS/ORNAMENTAL RAILING			1999	17,449	447	39	447		1,460	12
13	CARPET			2000	2,677	97	27.5	97		117	13
14	FENCING			2001	1,513	21	27.5	21		21	14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number ROSE GARDEN CONVALESCENT CENTER # 0041780 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 3,449,559	$ 95,608		$ 95,608	$ 0	$ 348,737	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ROSE GARDEN CONVALESCENT CENTER # 0041780 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 23,504	$ 3,392	$ 2,350	$ (1,042)	10	$ 7,335	71
72	Current Year Purchases	6,446	1,289	645	(644)	10	645	72
73	Fully Depreciated Assets				0			73
74	RELATED PARTY	275,745	32,427	27,575	(4,852)		107,663	74
75	TOTALS	$ 305,695	$ 37,108	$ 30,570	$ (6,538)		$ 115,643	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$ 0		$	76
77							0			77
78							0			78
79							0			79
80	TOTALS			$ 0	$ 0	$ 0	$ 0		$ 0	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 3,881,754	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 132,716	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 126,178	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (6,538)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 464,380	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: NA

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	DEC 31/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 44,470 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number ROSE GARDEN CONVALESCENT CENTER # 0041780 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition	$	$	$	$ 0
2	Books and Supplies				0
3	Classroom Wages (a)				0
4	Clinical Wages (b)				0
5	In-House Trainer Wages (c)				0
6	Transportation				0
7	Contractual Payments				0
8	Nurse Aide Competency Tests				0
9	TOTALS	$ 0	$ 0	$ 0	$ 0
10	SUM OF line 9, col. 1 and 2 (e)	$ 0			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number ROSE GARDEN CONVALESCENT CENTER # 0041780 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs	$		$ 40,784	$		$ 40,784	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			1,148			1,148	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			45,756			45,756	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts				56,286		56,286	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): LAB,RENTAL,SUPPL	39-2				1,719	9,091		10,810	13
14	TOTAL			$		$ 89,407	$ 65,377		$ 154,784	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number ROSE GARDEN CONVALESCENT CENTER # 0041780 **Report Period Beginning:** 01/01/2001 **Ending:** 12/31/2001

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2001 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$	$	1
2	Cash-Patient Deposits	1,400,946		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)			3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	54,820		6
7	Other Prepaid Expenses	1,167		7
8	Accounts Receivable (owners or related parties)	95,751		8
9	Other(specify): RE TAX ESCROW	2,411		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,555,095	$ 0	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	29,950		16
17	Accumulated Depreciation (book methods)	(17,229)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	16,150		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(16,150)		20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 12,721	$ 0	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,567,816	$ 0	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 276,064	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	195,000		29
30	Accrued Salaries Payable	74,543		30
31	Accrued Taxes Payable (excluding real estate taxes)	6,867		31
32	Accrued Real Estate Taxes(Sch.IX-B)	53,000		32
33	Accrued Interest Payable	37,354		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 642,828	$ 0	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	592,999		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 592,999	$ 0	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,235,827	$ 0	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 331,989	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,567,816	$ 0	48

***(See instructions.)**

Facility Name & ID Number ROSE GARDEN CONVALESCENT CENTER # 0041780 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 196,702	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 196,702	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	135,287	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 135,287	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 0	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 331,989	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number ROSE GARDEN CONVALESCENT CENTER # 0041780 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,510,819	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,510,819	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen	5,908	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 5,908	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 0	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 0	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 0	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,516,727	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	592,816	31
32	Health Care	1,220,735	32
33	General Administration	840,512	33
	B. Capital Expense		
34	Ownership	512,368	34
	C. Ancillary Expense		
35	Special Cost Centers	154,784	35
36	Provider Participation Fee	60,225	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,381,440	40
41	**Income before Income Taxes (line 30 minus line 40)****	135,287	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 135,287	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number ROSE GARDEN CONVALESCENT CENTER # 0041780 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,466	2,645	$ 52,440	$ 19.83	1
2	Assistant Director of Nursing	1,640	1,754	32,115	18.31	2
3	Registered Nurses	9,689	9,798	199,585	20.37	3
4	Licensed Practical Nurses	11,481	11,578	189,175	16.34	4
5	Nurse Aides & Orderlies	50,027	51,028	480,915	9.42	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,697	4,954	47,868	9.66	8
9	Activity Director					9
10	Activity Assistants	4,789	4,959	38,338	7.73	10
11	Social Service Workers	1,867	2,026	21,566	10.64	11
12	Dietician					12
13	Food Service Supervisor	2,995	3,030	41,684	13.76	13
14	Head Cook	3,468	3,571	26,183	7.33	14
15	Cook Helpers/Assistants	12,440	12,854	83,732	6.51	15
16	Dishwashers					16
17	Maintenance Workers	2,495	2,744	30,356	11.06	17
18	Housekeepers	13,060	13,709	97,349	7.10	18
19	Laundry	4,822	4,968	30,242	6.09	19
20	Administrator	1,804	1,968	61,446	31.22	20
21	Assistant Administrator	1,055	1,154	34,884	30.23	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,015	9,599	89,830	9.36	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	137,810	142,339	$ 1,557,708 *	$ 10.94	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	M	$ 0	1-3	35
36	Medical Director	O	6,598	9-3	36
37	Medical Records Consultant	N	0	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	1,140	10-3	39
40	Physical Therapy Consultant	L	5,400	10a-3	40
41	Occupational Therapy Consultant	Y	5,400	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	0	11-3	44
45	Social Service Consultant	E	3,176	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 21,714		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number ROSE GARDEN CONVALESCENT CENTER # 0041780 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
JIMMIE STEENBERGER	ADMIN	0	$ 28,893
STELLA DURDLE	ADMIN	0	32,553
GERALD BOCK	ASST ADMIN	0	34,884
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 96,330

B. Administrative - Other

Description	Amount
CAREPLUS MANAGEMENT	$ 8,000
HUNTER MANAGEMENT	15,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 23,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
CAREPLUS MGMT	DATA PROCESSING	$ 12,000
HEALTH DATA	DATA PROCESSING	2,100
CAREPLUS MGMT	ADMIN CONSLT	131,000
KRUPNICK, BOKOR, KAGDA	ACCOUNTING	24,300
MEYER MAGENCE	LEGAL	2,736
SACHNOFF WEAVER	LEGAL	15,368
RICHARD PEELO	MEDICARE CONSLT	3,750
PERSONNEL PLANNERS	UC CONSULTANT	3,652
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 194,906

D. Employee Benefits and Payroll Taxes

Description		Amount
Workers' Compensation Insurance		$ 42,879
Unemployment Compensation Insurance		16,979
FICA Taxes		119,222
Employee Health Insurance		9,955
Employee Meals		11,607
Illinois Municipal Retirement Fund (IMRF)*		
EMPLOYEE BENEFITS - OTHER		1,617
EMPLOYEE PHYSICAL EXAMS		0
PENSION/PROFIT SHARING PLANS		1,102
CHICAGO HEAD TAX		0
INSURANCE - EXECUTIVE LIFE		0
INSURANCE - EXECUTIVE LIFE	VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)		$ 203,361

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	9,014
Health Care Worker Background Check	14
(Indicate # of checks performed)	
MARKETING/ADV/PROMO	7,102
RELATED PARTY	2,981
CONTRIBUTIONS	1,510
DUES & SUBSCRIPTIONS	4,170
LICENSES & PERMITS	540
LESS CONTRIBUTIONS	(1,510)
Less: Public Relations Expense	(0)
Non-allowable advertising	(2,475)
Yellow page advertising	(4,627)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 16,719

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	878
RELATED PARTY	344
Seminar Expense	
	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,222

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number ROSE GARDEN CONVALESCENT CENTER # 0041780 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	PAINT/DECORATING	2000	$ 4,671	3	$	$	$ 779	$ 1,557	$ 1,557	$ 778	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 4,671		$	$	$ 779	$ 1,557	$ 1,557	$ 778	$	$	$

Facility Name & ID Number ROSE GARDEN CONVALESCENT CENTER **#** 0041780 **Report Period Beginning:** 01/01/2001 **Ending:** 12/31/2001

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? YES

(2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. IL COUNCIL LONG TERM CARE $ 4170

(3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YR

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ 0 Line 10-2

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ 60,225
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ 11,607 Has any meal income been offset against related costs? N/A Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? 5%
d. Have vehicle usage logs been maintained? NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? YES

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees.

Facility Name & ID#: ROSE GARDEN CONVALESCENT CENTER #0041780 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	4,084	
	REPAIRS & MAINTENANCE		0	
			0	4,084
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		0	
			0	0
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		24,642	
	ELECTRICITY		29,918	
	WATER		4,932	
	CABLE TV - LOBBY		512	
			0	60,004
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		5,861	
	PAINTING & DECORATING		1,403	
	BUILDING REPAIRS		396	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		9,372	
	ELEVATOR MAINTENANCE & REPAIR		0	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		2,860	
	FIRE SERVICE		769	
			0	
			0	
			0	20,661
7	**OTHER**			
	SCAVENGER		7,065	
	SECURITY SERVICE		0	7,065
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	6,598	6,598

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2		
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	0	
	PHARMACY CONSULTANT	XVIII B 39-2	1,140	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	0	
			0	
			0	1,140
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		31,662	
	SPEECH THERAPY SERVICES		2,201	
	OCCUPATIONAL THERAPY SERVICES		22,825	
	THERAPY CONTRACT SERVICES		9,060	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	5,400	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	5,400	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	76,548
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	0	
			0	0
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		162	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	3,176	
			0	3,338
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number ROSE GARDEN CONVALESCENT CENTER **#0041780** **Report Period Beginning:** 01/01/2001 **Ending:** 12/31/2001

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		0	0
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	23,000	23,000
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	14,100	
	ADMINISTRATIVE CONSULTANTS	XIX C	131,000	
	PROFESSIONAL FEES	XIX C	49,806	
			0	194,906
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	2,475	
	EMPLOYEE WANT ADS	XIX F	9,014	
	CONTRIBUTIONS	VI 20 XIX F	0	
	DUES & SUBSCRIPTIONS	XIX F	4,170	
	LICENSES & PERMITS	XIX F	540	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	4,627	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	1,510	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	14	22,350
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES		0	
	EQUIPMENT REPAIR & MAINTENANCE		9,721	
	OUTSIDE CLERICAL SERVICES		66,000	
	PENALTIES / OVERDRAFT CHARGES	VI 18	15,528	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		16,773	
	MESSENGER SERVICE		1,021	
			0	109,043

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	119,222	
	UNEMPLOYMENT COMPENSATION	XIX D	16,979	
	WORKERS COMPENSATION INSURANC	XIX D	42,879	
	HOSPITALIZATION INSURANCE	XIX D	9,955	
	EMPLOYEE BENEFITS - OTHER	XIX D	1,617	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	1,102	
		XIX D		191,754
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		1,156	1,156
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	878	
			0	
			0	878
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		7,472	7,472
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		95,710	95,710
27	**OTHER**			
	BAD DEBTS	VI 24	0	
			0	0

GRAND TOTAL COLUMN 3 OTHER 825,707

ROSE GARDEN CONVALESCENT CENTER
EMPLOYEE MEAL RECLASSIFICATION
12/31/2001

TOTAL FOOD PURCHASE	119,928
LESS SALES TAX	560
NET FOOD	119368
TOTAL PATIENT CENSUS	33,855
TIME 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	101565
ADD # EMPLOYEE MEALS/DAY	30
TIME # DAYS	365
TOTAL EMPLOYEE MEALS	10950

PATIENT MEALS	101565
ADD EMPLOYEE MEALS	10950
TOTAL MEALS/YEAR	112515
NET FOOD	119368
DIVIDE TOTAL MEALS/YEAR	112515
COST PER MEAL	1.06
TIME EMPLOYEE MEALS	10950
EMPLOYEE MEAL RECLASSIFICATION	11607